

Treatment Program for Mental Hospitals

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THE "CONTINUED TREATMENT" WARDS in the mental hospitals of this country house many thousands of patients. They are all too frequently wards of regression rather than of treatment because the institutions do not have big enough staffs to provide for patients newly received and at the same time carry out an effective treatment program for the many thousands of chronic patients who use at least 75 per cent of the beds in any state hospital. Persons concerned with clinical programs have been hoping for many years to have enough psychiatrists, psychologists, social workers and rehabilitation personnel to make all the accepted treatment techniques available for all patients. But the hope has been in vain and hospital staffs have compromised by giving to new patients practically all their resources.

Yet patients who need continued treatment should not be deprived of effective help simply because the best help for them is not available. A program of satisfactory custody is not enough. Living in crowded quarters, eating monotonous food, being poorly groomed, wearing clothes almost identical to those of others in large groups and existing with little or no interesting activity programs — inevitably this accustoms a patient to a very low cultural and social life and thus provides a compelling opportunity for his already weakened ego to sink further into a state of disintegration, withdrawal and, finally, vegetation. Certainly the patient must feel emotionally abandoned and lost.

Such patients are in large measure the persons for whom acute treatment was unsuccessful and who, after years of living in a mental hospital, are described in the progress notes (sic!) as "flattened out" or "burned out" or "regressed" or "deteriorated." The author believes that much of this disintegration is directly due to the environment in the average "continued treatment" ward of our mental hospitals, and is in very considerable measure reversible. The professional leadership provided by those disciplines that are represented on the hospital staff but are in short supply must be utilized in a new and continuing framework to prevent this condition and to accomplish all possible rehabilitation

• Many thousands of patients in the "chronic" wards of mental hospitals have been considered unsuitable subjects for active treatment, on the assumption that little could be accomplished. However, a well integrated therapeutic program under skilled psychiatric direction and involving all personnel who will come in contact with the patient gives promise of returning a substantial number of patients to their homes. The program suggested in this paper also retards personality disorganization and refutes the current nihilistic attitude concerning the patient whose mental condition has been deemed to be chronic.

of those patients already regressed because of environment and clinical neglect.

"Total push" is not a new concept. Great effort has gone into solving the problem of how to effectively treat the chronically ill patient.¹⁻⁷ However, what perhaps has been lacking in the past is the implementation of the techniques on all wards on a continuing basis. In other words, the research has been fruitful but its practical application in terms of maximum results with a minimum staff has not yet been forthcoming to a significant degree.

The suggestions that follow do not embrace anything particularly new to hospital psychiatry or institutional practice. They are an extension and increased emphasis upon present-day techniques that are well established and quite generally practiced in the acute areas of most hospitals. As applied to continued treatment or chronic areas they will be universally successful provided certain all-important and primary concepts are accepted and practiced. It is recognized that the professional staffs of the hospitals will need to spend many hours conferring and planning, checking, changing and improving, but it must be said that this process itself is highly educational and integrative for the staff, and that not only does the patient benefit immeasurably, but so does the staff, because it feels less frustrated, less overwhelmed and recognizes that its knowledge is radiated in such a way as to be useful to much larger numbers of patients than can be individually treated. Most important of all techniques in the approach to be described is *attitude*.

Leadership personnel of the hospital, and this

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includes the nursing and supervising personnel, must be interested in providing treatment for *all* the patients and must feel certain that the policy of the hospital administration is patient-centered and founded upon the hope and belief that all the patients can be fruitfully treated. Treatability is the crux of the matter because much of the success of such a program depends upon a hopeful attitude. It may take a year or two in an average hospital to effect a demonstrable impact upon the patients' welfare because attitudes are not easily changed and old ways are cherished, and because the whole hospital must have a sense of high purpose, a dedication to the proposition that no patient can be considered hopeless until he is dead.

Assuming that the institutional leadership has determined upon a practical integrated hospital-wide treatment program, and has begun to instill the attitudes expressed above, what is the next step? It is to perfect integrated teamwork throughout the institution. Groups functioning together for specific purposes do not just happen because someone wills it. Group dynamics indicate that effective teams have to be built for a definite purpose and with an understood philosophy. This means working together, each member contributing the skills he has within a well-defined and understandable continuing treatment program.

While teamwork is in itself not a new concept, its planned and continuing use on each ward of most hospitals is still in its infancy. Doctors, psychologists and social workers have worked in the teamwork situation in mental hygiene clinics and in the acute section of mental hospitals for years, and it is an extension and amplification of this concept that is basic in a treatment program for chronic patients.

Early in the construction and operation of the team it is not uncommon to find that some members of one or another of the represented professional groups do not know how to separate from their skills those things that can be done by others who have not had similar educational opportunities. There are, in fact, many skills in dealing with patients that can be taught to others and used under adequate supervision and leadership and that will greatly benefit patients.

Sometimes a state of tension develops in the relationships of psychiatrists, psychologists and social workers who work together. Occasionally a psychiatrist will feel that a psychologist or social worker is attempting to do things that are within the province of the psychiatrist. The same attitude is frequent, of course, in all disciplines. Teamwork definitely diminishes these tensions. It is readily apparent to all that a tremendous job has to be done and that since there are few people to do it, there is a compelling need for communication of some skills to others who

have had less professional training, but always under competent supervision.

THE PSYCHIATRIST AS TEAM TEACHER

It is imperative to extend the teamwork concept beyond the three disciplines just mentioned to include rehabilitation therapists, psychiatric nurses and psychiatric technicians. The last three disciplines mentioned are the real key to program success or failure. The psychiatric technicians are the least intensively trained of all those who come in contact with patients. They are, however, the ones who spend the most time with patients. Therefore, the technicians must become part of the team in fact as well as in name. To be effective in treatment, all these disciplines must derive their leadership and supervision from a competent psychiatrist, who, by virtue of his leadership, is able to disseminate his skills and knowledge to a remarkable extent. He must necessarily develop the art of communication to such a degree that he can be understood by all his teammates.

Most psychiatrists are capable of effective leadership of this type if they are motivated to develop it. The leader will soon find that in sharing his skills and encouraging the other members of the team to do likewise, he has become a first-rate teacher utilizing discussion and group conference.

Many psychiatric technicians have not had an opportunity to function in a treatment situation beyond the traditional role of "attendant"—a word whose very meaning implies passivity. They have worked in a world bounded by daily routine and lock and key. It admittedly takes time, patience, and enthusiasm to give this group the desire and the ability to work in a treatment team, but such is the alchemy of group dynamics that the reorientation is accomplished and new skills acquired. Many psychiatric technicians, however, because of the old role they have played and because of the fact that they have had little or no training over the years, feel inadequate to the new function expected of them and become anxious. This initial difficulty is quickly overcome by a good leader-psychiatrist. The psychiatric technician becomes pleased by his new role and subsequently becomes caught up by the positive and hopeful group attitude.

However, as time goes on he is required to learn and *do* more and more with patients, and there comes a point where he is in more acute conflict between his new functions and those that have been traditional. Somehow the ward looks a little less ship-shape, and there is a relaxed atmosphere about the place that tends to be disturbing. The patients are more difficult because it has been found that patients once almost immobile become active and

sometimes hostile as they begin to improve. It is at this point that leadership and teamwork are of crucial importance. Anxieties must be reduced, discouragement talked through, and patients' behavior interpreted. Once the psychiatric technician has gotten over this hurdle, he is indeed a team member.

Rehabilitation therapists (occupational therapists, recreational therapists, musical therapists and librarians) are for the most part accustomed to working with relatively small groups of patients in a somewhat structured program usually within the four walls of the same room. When asked to take their skills to very large numbers of patients and from ward to ward, many are worried at the prospect and need reassurance and teamwork training. They must learn, like other members of the treatment group, to adapt their techniques to large groups and to help the psychiatric technician acquire definite skills so that the activity program will be continuous. The rehabilitation therapist is of really great importance in the team because he is in large part the medium through which the patient is coaxed into closer touch with reality through remotivation and improved interpersonal relationship. The sequence of this approach is to help the patient acquire a relationship with one of the team personnel, then with another patient, and later with a group of patients, thus bringing the patient gradually into an ability to live once more in a social group. The structure and integrated motivation of the group are all-important.

The special training of psychiatric nurses makes them invaluable, not only in working with patients, but in the training of psychiatric technicians by setting the tone and giving more therapeutic meaning to the whole of the patient's ward life.

Special mention should be made of the part that psychiatric social workers play in the scheme of things. Many of the hospital personnel need greater understanding of the functions of a psychiatric social worker. A program of this type offers an excellent opportunity for interpretation. This professional group plays an important part in interpreting to patients' relatives what is being done for the patient so that indifference on the part of relatives will give way to a more hopeful and constructive attitude toward placement of the patient in a home. Many patients will need special placement, perhaps in a "family care home" or in a job. All this is extremely important in properly handling the end result of the program.

ON-THE-JOB TRAINING FOR TEAM

The training and integration of the treatment team are best undertaken on the job. This means the consideration of the needs of each patient on the ward. Talking about patients gives the leader excellent

opportunity to encourage the expressing of attitudes directed toward individual patients and also provides the logical material for seminar discussions. The leader will be pleased at the rapidity of growth of constructive interest, particularly by the psychiatric technicians.

Activities that need to be devised are calculated to motivate the patient in the direction of or reintegration with, at best, community placement; at least, better hospital citizenship. The patient must be encouraged in every way possible to improve his interest and function in the small everyday business of living: Eating, shaving, bathing, dressing, care of the hair, shoe-care, attention to fingernails, and so forth. This list seems unimpressive, but it is astonishing what careful attention along these lines will do for the patient. An excellent article by Alfred W. Deibel, "Caring for the Mentally Ill in a Democratic Setting," described a habit-training approach which supports the grossly weakened ego and provides a vehicle for demonstrating to the patient that everyone is interested in him as a person, that improvement is possible and expected. Obviously the interest and the enthusiasm of the psychiatric technician in the individual patient is the key. Another very valuable technique is to get the patient to read to a group or to join in responsive reading. This reading technique takes a great deal of time and patience, but in a study conducted at the Stockton State Hospital it was found to be very effective.

Space does not permit a detailed account of each treatment method that can be utilized. Human ingenuity with strong motivation can be depended upon to provide all sorts of group activities. However, one approach that deserves special mention is one of the many group therapy techniques: The group is led by a patient (but supervised by a psychiatrist who sits in as consultant) in a discussion of general mental health and also in special problems presented by individual patients. A tape recorder is utilized and after the session is over the contents are played back to the group. The effect upon the patient of hearing what he has said is frequently remarkable. Curiously, he often develops some insight into the fact that his delusions and hallucinations sound very strange and unbelievable when he hears his own voice telling about them. His reactions to these symptoms tend to diminish in intensity.

At Stockton it was found wise to assign small groups of patients to individual technicians in order to be sure that all patients were being worked with. A ratio of one nursing service employee to every 2.1 patients was maintained in order to be sure that the program would not suffer because of inadequate ward personnel. It is believed that this heavy staffing can be considerably modified by further trial, and experiments are now being carried out at two

other hospitals in order to arrive at figures which will give maximum results at a minimum cost. Good results can be obtained even when dealing with patients who seemingly are pretty hopelessly ill. True, many of them will not leave the hospital, but for those who do, it is a great victory, and for those who do not, their stay in the hospital continues to be more profitable for themselves and often more helpful to the institution.

Obviously no institution can institute a program such as this in all wards at the same time. It has to begin by training a team on a ward or two and then by spreading gradually as the integrated team is able to circulate its attitudes and methods to other teams. The professional members of the team become members of several ward teams. It is very important, however, to recognize that this particular approach will only be successful if it becomes a continuing part of everyday hospital care. The methods sketched here, backed by an optimistic attitude, will improve the therapeutic approach even in situa-

tions where there is not sufficient staff to do the whole job.

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REFERENCES

1. Galioni, E. F., Adams, F. H., and Tallman, F.: Intensive treatment of backward patients, *Am. Jour. Psychiat.*, 576-583, Feb. 1953.
2. Halloran, R. D., Corwin, W., and Semrad, E. V.: Adaptation of total push treatment principle to state hospital at large, *Dis. Nerv. Sys.*, 3:371-374, Nov. 1942.
3. Miller, D. H., and Clancy, J.: An approach to the social rehabilitation of chronic patients, *Psychiatry*, 15:43-443, Nov. 1952.
4. Shapiro, L. E.: Administration of the continued treatment service, *Psychiat. Quar.*, 26:439-449, July 1952.
5. Myerson, A.: Theory and principles of the total push method in the treatment of chronic schizophrenia, *Am. J. Psychiat.*, 95:1197-1204, March 1939.
6. Myerson, A.: Total push method: Schema for recording of certain important attitudes in chronic schizophrenia, *Am. J. Psychiat.*, 96:935-943, Jan. 1940.
7. Tompkins, H. J., and Ozarin, L. D.: Changing concepts of the role of the institutional psychiatrist, *Psychiat. Quar. Supp.*, 24:23-34, 1950.

Expresses Views on Fee-Splitting Publicity

AN EXCELLENT, down-to-earth article, written by Dr. Stanley S. Truman, past-president of the American Academy of General Practice, and expressing his views on the furor and publicity attendant on the *Collier's* story of October 30, appears in the December issue of *GP*, the academy's publication. If you have access to this journal, Dr. Truman's article is well worth reading.

—A.M.A. Secretary's Letter